SUPPLEMENTAL MEDICAID SCHEDULE KMAP-4

DISPROPORTIONATE SHARE HOSPITAL QUESTIONNAIRE

FACILITY: _____ FYE: _____

VENDOR NUMBER: _____

1a. Did your facility offer nonemergency obstetric services as of December 21, 1987? (ANSWER YES "ONLY" IF THERE WERE "AT LEAST" 2-OB'S OR PHYSICIANS WHO OFFERED EMERGENCY OBSTETRIC SERVICES.)
Yes _____
No _____

b. Does your facility predominantly serve individuals under 18 years of age?
Yes _____
No _____
If yes, indicate the percent of the individuals under 18 years of age.
% _____

c. Does your facility have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medicaid eligible individuals? In the case of a hospital located in a rural area (that is an area outside a Metropolitan Statistical Area), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.
Yes _____
No _____

2. Enter the total Medicaid inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments.
$ _____

3. Enter the total inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments.
$ _____

4. Enter the total amount of the facility's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources).

   The total inpatient charges attributed to charity care should not include bad debts or contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

   The charges should be net of any cash subsidies for patient services received directly from state and local governments in the period attributable to inpatient hospital services.
$ _____

5. Enter the total amount of the facility's charges for inpatient services.
$ _____

The above statements are accurate and correct to the best of my knowledge.

Signed: _____
President, Administrator, or Chief Financial Officer

SUPPLEMENTAL WORKSHEET KMAP-5

(TITLE XIX DEPRECIATION)

HOSPITAL _____

VENDOR # _____

PERIOD FROM _____ PERIOD TO _____

REASON FOR REVISION _____

A. INSTRUCTIONS

B. CAPITAL COST COMPUTATION

1A. TOTAL DEPRECIATION (W/S B. PART II COLUMN 2A - LINE 95) LESS INTEREST/INSURANCE/TAXES (W/S A-6 AND W/S A-8) = ADJUSTED TOTAL DEPRECIATION

LINE 1B. | | | |

2A. ADJUSTED TOTAL DEPRECIATION (LINE1) / TOTAL DEPRECIATION =RATIO

LINE 2B. | | | |

3A. RATIO (LINE 2) X TITLE XIX CAPITAL COST (ROUTINE AND ANCILLARY W/S D. PARTS I AND II = ADJUSTED TITLE XIX CAPITAL COST (TITLE XIX CAPITAL COST LESS INT. /INS./TAXES)

LINE 3B. | | | |

4A. TOTAL BLDG. AND FIXTURES / TOTAL DEPRECIATION = RATIO (W/S B. PART II, COL. 01, LINE 95) (W/S B, PART II, COL. 2A. LINE 95) (RATIO OF BLDG. AND FIXTURES TO TOTAL DEP)

LINE 4B. | | | |

5A. RATIO (LINE 4) X TITLE XIX ADJUSTED CAPITAL COST (LINE 3) = TITLE XIX BLDG. AND FIXTURES DEP.

LINE 5B. | | | |

6A. TITLE XIX CAPITAL COST LESS TITLE XIX BLDG. DEPRECIATION (LINE 5) =TITLE XIX MOVABLE EQUIP. AND INTEREST/ INSURANCE DEP.

LINE 6B. | | | |

7A. 65% X TITLE XIX BLDG. DEP (LINE 5) = ALLOWABLE TITLE XIX BLDG. DEP.

LINE 7B. | | | |

8A. TITLE XIX EQUIPMENT AND INTEREST/INSURANCE DEPRECIATION (LINE 6) + TITLE XIX ALLOWABLE BLDG. DEPRECIATION (LINE 7)=MEDICAID ALLOWABLE INPATIENT CAPITAL

Line 8B. | | | |

N No. 91-6
Supersedes
TN No. 90-2

Approved MAY 08 1991 Effective Date 1-1-91

SUPPLEMENTAL MEDICAID SCHEDULE KMAP-6

PROFESSIONAL COMPONENT/LABOR-DELIVERY ROOM DAYS/NURSERY INFORMATION

HOSPITAL _____
VENDOR NUMBER _____ AUDITOR _____
PERIOD FROM _____ DATE _____
PERIOD TO _____ REVIEWER _____
DATE _____

A. HOSPITAL-BASED PROFESSIONAL COMPONENT SERVICES

COST CENTERS	Col. 1 TOTAL PROFESSIONAL COMPONENT CHG. INPATIENT	Col. 2 TOTAL TITLE XIX PROFESSIONAL COMPONENT CHG. INPATIENT	Col. 3 TOTAL PROFESSIONAL COMPONENT CHG. OUTPATIENT	COL. 4 TOTAL TITLE XIX PROFESSIONAL COMPONENT CHG OUTPATIENT
ANESTHESIOLOGY				
RADIOLOGY-DIAGNOSTIC				
RADIOLOGY-THERAPEUTIC				
RADIOISOTOPE				
LABORATORY				
EKG				
EEG				
PSYCHIATRY				
EMERGENCY ROOM				

WHEN PROFESSIONAL COMPONENT SERVICES ARE INCLUDED IN THE COST REPORT, A SUPPLEMENTAL WORKSHEET D-3 SHOULD BE COMPLETED. ALSO, THIS OFFICE MUST RECEIVE THIS SUPPLEMENTAL SCHEDULE IDENTIFYING, BY COST CENTERS, THE TOTAL PROFESSIONAL COMPONENT CHARGES AND THE TITLE XIX PROFESSIONAL COMPONENT CHARGES.

B. LABOR/DELIVERY ROOM DAYS

DOES TOTAL HOSPITAL ADULT AND PEDIATRIC DAYS (EXCLUDING SWING BEDS) ON WORKSHEET S-3 (HOSPITAL STATISTICAL DATA) LINE 1.A, COLUMN 6 INCLUDE LABOR/DELIVERY ROOM days.

YES _____ NO _____

IF NO, PLEASE INDICATE TOTAL LABOR/DELIVERY ROOM DAYS. _____

C. NURSERY DAYS

PLEASE INDICATE THE FOLLOWING:

1. THE NUMBER OF MEDICAID NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. _____
2. THE NUMBER OF MEDICAID NURSERY DAYS ON WORKSHEET S-3, COLUMN 5 THAT ARE ZERO PAID. _____
3. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. _____
4. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE ZERO PAID. _____

SUPPLEMENTAL MEDICAID SCHEDULE KMAP-8

COMPUTATION OF EXCLUDED ALLOWABLE PROFESSIONAL COST

WHICH IS NOT REIMBURSABLE BY KMAP ON WORKSHEET D-3

FACILITY: _____

VENDOR #: _____ PERIOD FROM _____ PERIOD TO _____

COL. 1 Cost Centers	COL. 2 Cost From Wk/S A-8 or A-8-2
1. CRNA	
2. Physical Therapist	
3. Respiratory Therapist	
4. Other	
5. Other	
6. Total	

7. Determine a ratio of Hospital Inpatient Cost to total Hospital Cost _____

8. Determine a ratio of Hospital Outpatient Cost to total Hospital Cost _____

9. Multiply the ratio from Line 7 & Line 8 by the total amount entered on line 6 to determine the cost applicable to Inpatient and Outpatient services.
   a. Inpatient Cost (Excluded Allowable Professional Cost) _____
   b. Outpatient Cost (Excluded Allowable Professional Cost) _____

10. Determine the ratio of Title XIX Inpatient Cost to total Inpatient Cost _____

11. Determine the ratio of Title XIX Outpatient Cost to total Outpatient Cost _____

12. Multiply the ratio of Title XIX Inpatient Cost Line 10 by the amount entered on line 9a for Title XIX Inpatient Cost. Enter the amount on Wkst. E-3 Part III, Line 7b, Col. 1. _____

13. Multiply the ratio of Title XIX Outpatient Cost Line 11 by the amount entered on line 9b for Title XIX Outpatient Cost. Enter the amount on Wkst. E-3 Part III, Line 7b, Col.2. _____

INSTRUCTIONS

LINE #

7. Divide the sum of Worksheet B, Part I, col. 27, lines 25 through 33, lines 37 through 59, and line 70 by the sum of Worksheet B, Part I, col. 27, lines 25 through 33, lines 37 through 59, lines 60 through 62 and line 70.
8. Divide the sum of Worksheet B, Part I, col. 27, lines 60 through 62 by the sum of Worksheet B, Part I, col. 27, lines 25 through 33, lines 37 through 59, lines 60 through 62 and line 70.
10. Divide the amount of Title XIX Inpatient cost (HCFA 2552-89,12/89, E-3, Part III, Col. 1 Total of lines 1 through 6) by the Total Hospital Inpatient Cost (Sum of Worksheet B, Part I, col. 27 lines 25 through 33, lines 37 through 59, and line 70).
11. Divide the amount of Title XIX Outpatient cost (HCFA 2552-89, 12/89, E-3 Part III, Col. 2 Total of lines 1 through 6) by the Total Hospital Outpatient Cost (Sum of Worksheet B, Part I, col. 27, lines 60 through 62).

SUPPLEMENTAL MEDICAID SCHEDULE KMAP-9

HICAP Cost Applicable to Hospital Reimbursement Rates

HOSPITAL _____

VENDOR NO _____

FYE _____

1. Total Hospital Cost
   (Worksheet A Col. 7 Line 95 Less
   Cost Other Than Hospital Cost) _____

2. Medicaid Inpatient Cost
   (E-3 Part III Line 42) _____

3. Medicaid Outpatient Cost
   (E-3 Part III Line 50A Plus
   D Part III Line 44 Col. 3) _____

4. HICAP ASSESSMENT _____

5a. Total Medicaid Inpatient Cost (line 2) divided by Total Hospital Cost (line 1) equals Ratio

5b. | | | |

6a. HICAP ASSESSMENT (Line 4) times Ratio (Line 5b) equals Allowable Medicaid Inpatient Cost Attributable to HICAP ASSESSMENT

6b. | | | |

7a. Total Medicaid Outpatient Cost (Line 3) divided by Total Hospital Cost (Line 1) equals Ratio

7b. | | | |

8a. HICAP ASSESSMENT (Line 4) times Ratio (Line 7b) equals Allowable Outpatient Hospital Cost Attributable to HICAP ASSESSMENT

8b. | | | |

114. DEFINITIONS:

The following terms are used throughout the manual and are defined in the following context.

a. Base year - The base year is the calendar year prior to the universal rate year. Under this system, payment to hospitals is determined prospectively by establishing a base year cost for the hospital. The base year cost for the hospital is the latest available Medicaid cost report data trended to the beginning of the universal rate year using the Data Resources, Inc. trend factor.

b. Cost Basis - Cost basis refers to the total allowable Medicaid inpatient costs incurred by the provider in the base year.

c. Universal rate year - The universal rate year, under the prospective payment system is the year beginning January 1 for which payment rates are established for all hospitals for a 12 - month period regardless of the hospital's fiscal year end.

d. University - affiliated/teaching hospital - A hospital is designated to be a teaching/university - affiliated hospital if the hospital is operated for the purpose of education and/or research and receives its primary source of funding from the Kentucky Council on Higher Education.

e. Low Income Utilization Rate - For a hospital, the sum (expressed as a percentage) of the fraction, calculated as follows:

i. Total Medicaid inpatient revenues (payments) paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues (payments) of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

ii. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided for individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies for patient services received directly from the State and local governments in the period attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

115. PSYCHIATRIC HOSPITALS SUPPLEMENT

(a) Introduction

This Inpatient Hospital Reimbursement Manual Supplement sets forth a cost related, prospective payment system for inpatient psychiatric hospitals, except for those hospitals specified in Section 115 (g), which are providing services to Title XIX (Medicaid) recipients and which are to be reimbursed under the Kentucky Medical Assistance Program of the Department for Medicaid Services. Except as specified in this supplement, policies and procedures as stated in the Title XIX Inpatient Hospital Reimbursement Manual are applicable.

(b) Uniform Rate Year

Effective August 3, 1985, a prospective payment system based on a uniform rate year (July 1, 1985 through June 30, 1986) is established utilizing the most recent available annual cost report data with costs trended to the beginning of the rate year and indexed for the prospective rate year; however, effective January 1, 1986, the prospective rate year shall be reestablished and shall be January 1 through December 31 of each year thereafter.

(c) Maximum Payment

The upper limit shall be established at the weighted median of the array of allowable costs for all participating psychiatric hospitals, except that disproportionate share hospitals, as defined in this Section, shall have a payment rate calculated in accordance with Section 102A.

(d) Disproportionate Share Hospitals

Psychiatric hospitals which qualify as disproportionate share hospitals are Type VII disproportionate share hospitals.

(e) Hospitals having a Medicaid utilization of 35 percent or higher shall have an upper limit established at 115 percent of the weighted median.

(f) Occupancy Factor

A minimum occupancy level will be imposed relative to Medicaid inpatient capital cost as outlined in Section 105.